



Ashley Dalton MP
Parliamentary Under-Secretary of State for Public Health and Prevention
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By email to: ashley.dalton.mp@parliament.uk

Your reference: MC2025/44435

9th July 2025

Dear Minister,

Thank you for your letter dated 27th June 2025 in response to my earlier correspondence on 18th March 2025 on behalf of the COVID-19 Airborne Transmission Alliance (CATA). While it is a response, we still feel it falls short of meeting the standard of demonstrating that you are taking account of relevant considerations (the current state of scientific knowledge, workplace health policy and applicable law). We have written to correct subsequent misstatements in later correspondence on 1st May 2025 and 27th June 2025, with (hopefully) helpful clarifications on the matter.

We have outlined inconsistencies and inaccuracies below. This is in order to further assist you in identifying issues which are of substantial concern and which, we are advised, taint decisions by the Department in this area with illegality.

1. Particle size is not an academic matter:

The nuanced approach to the classification of particle size is possibly helpful in tackling the semantics and politics of this issue. However, size does matter. Just as a feather moves through the air differently from a cannon ball, so too does a particle which has insufficient mass to fall, compared to a droplet which is subject to the laws of gravity. These are matters of physics, not terminology. For the determination of protective equipment, size is also crucial. Small particles require fine filtration, but larger particles do not. The boundaries of particle size are critical to the determination of what type of filtering face piece is required, if at all.

2. Material inaccuracies remain uncorrected:

The advice issued by the Department continues to downplay or misrepresent the role/significance of airborne transmission of COVID-19. This continues despite overwhelming peer-reviewed evidence, the consistent guidance from international bodies such as the CDC and WHO and it is the clear position of the UK Government's own scientific advisors. We would draw your attention to the advice given by Professor Mark Wilcox OBE, National Speciality

Advisor for IPC (NHS England), expert advisor on Healthcare Associated Infections and a leading member of the former "IPC Cell". As he will undoubtedly be able to confirm for you, his opinion (expressed as long ago as March 2022) confirmed the importance of aerosol transmission: ***"The reality is that virus transmission via the air is a continuum of possibilities including large particles (droplets) and small particles (aerosols). The longer someone spends in close proximity to an infectious person in a poorly ventilated setting, the greater the risk of virus transmission"***. This description clearly applies to a healthcare worker providing close-quarter care to an infectious patient in circumstances where their two breathing zones overlap, regardless of general room ventilation which cannot generate sufficient air velocity to sweep away the plume of exhaled infectious breath.

3. The assertion that COVID-19 is "not predominantly spread" via the airborne route is not compatible with current UK Government evidence, the National Core Study, and scientific consensus. Regardless of whether airborne transmission is predominant or not, the approach outlined in your letters undermines the employers' duties to protect against all modes of transmission.
4. **Regulatory compliance has not been addressed:**
We are relieved to hear that guidance is being reviewed in line with the Control of Substances Hazardous to Health Regulations and that you acknowledge the duty owed by employers. However, the IPC manual, which is the responsibility of your Department, continues to stand at odds with the law, as previously outlined. Your letter implies that the duty to ensure workers are protected from biological hazards lies at the feet of employers. National policy can and will significantly influence how decisions are made around compliance with the law. Your letters and the material promoted in them will continue to encourage healthcare employers to act illegally.
5. **Lack of specificity of response:**
Our most recent letter set out two direct questions seeking the Department's justification for its position based on current peer-reviewed evidence and clarification on why the Department is not ensuring UK health bodies are correctly directed in line with the law and scientific consensus. These are critical to our determination of whether we need to take the next step in preparation for a judicial review of the Department.
6. **Ongoing risks and impact on healthcare services:**
You have not addressed our concerns about the continuing exposure of healthcare workers to airborne transmission risks in various settings, including maternity care, and the knock-on effects this has on staffing, safety, and patient outcomes.

We once again request a scientifically and legally informed response to avoid the need to compel a determination through the judicial review process.

As previously noted, it is not our wish to escalate this issue with time and expense. We still find it nearly incomprehensible that the Department continues to disregard the overwhelming scientific evidence and the law of the land. The consequences of poor management of airborne respiratory infections by the NHS cost 4.4 million days off in 2022 (COVID-19) and 440,000 days off for other illnesses with an airborne component. We estimate that the cost of not addressing the spread of airborne diseases within healthcare will be upwards of a billion pounds a year in agency costs, overtime, additional staffing required and wasted appointments.

This is a stunning amount of waste. The absence of monitoring of the extent of any nosocomial infections which have an airborne transmission route may be masking a huge patient safety issue. You will have personal knowledge of the huge risks to vulnerable patients from respiratory infections which are prevalent in healthcare settings, despite routine IPC and droplet precautions.

While we cannot expect the Department to have a solution for the seasonal disaster to health and the economy of respiratory diseases, we can expect an approach which progresses beyond “coughs and sneezes spread diseases”, “catch it and bin it” and handwashing. Controlling airborne infections is hard and expensive, but the risk of not doing so is significantly greater, as is the ongoing cost of ignoring it.

We remain committed to supporting the Government in promoting effective public health measures and would much prefer to work together to achieve a shared understanding and appropriate action. It would be so much more constructive for the government to engage with the world-leading expertise in our membership to find solutions, rather than us responding to excuses and poorly-informed and constructed responses from your support team.

Thank you for your attention to this matter. We look forward to your response.

Yours sincerely,

Professor Kevin Bampton

Chief Executive Officer

British Occupational Hygiene Society

On behalf of the CATA Executive Team:

Dr Barry Jones, Chair BSc MBBS MD FRCP

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